

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395396	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 03/17/2023
NAME OF PROVIDER OR SUPPLIER: WILLIAMSPORT SOUTH REHABILITATION AND NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE: 101 LEADER DRIVE WILLIAMSPORT, PA 17701		
STATE LICENSE NUMBER: 641502					
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F 0000	INITIAL COMMENT	F 0000			
F 0584	Based on a Medicare/Medicaid Recertification Survey, State Licensure Survey, Civil Rights Compliance Survey, and Complaint Investigation, completed on March 17, 2023, it was determined that Williamsport South Rehabilitation And Nursing Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0584			
SS=E					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

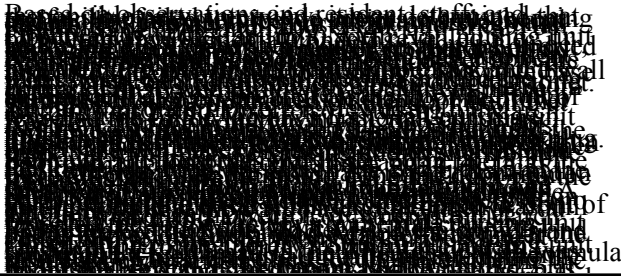
Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0584 SS=E	Continued from page 1 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all	F 0584	1. Resident 8's room was deep cleaned including but not limited to floor, privacy curtain, and cove basing. Resident 79's bathroom end of water line pipe was covered, wall and cove base and flooring was cleaned. Resident 84's bathroom caulking around the toilet was replaced and floor was cleaned around toilet. Resident 95's cove basing in the room was cleaned including but not limited to the corners. Resident 203's room floor was cleaned. Resident 2's room windowsill was cleaned and dusted. Resident 20's towel bar was repaired. Resident 20's bathroom base of the toilet was cleaned to removed rust and dirt. Resident 20's bathtub was cleaned including but not limited to around the drain. Resident 20's cove base was cleaned throughout the entire room where it meets the floor to remove any build up. Resident 20's window was repaired to ensure it closes tightly. Residents 20's wallpaper was repaired in the room. Resident 20's door trim was repaired. Resident 37's room was cleaned	Completion Date: 05/02/2023 Status: APPROVED Date: 03/31/2023	

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F 0584 SS=E	Continued from page 2 areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 0584	including but not limited to the corner behind the door and along the cove base in bathroom and in the room. Resident 41's room was cleaned including but not limited to the corner behind the door and the cove base in the entire room and cove base in the bathroom. Resident 41's bathroom door and door frame, and back of the door to the room were repaired. Resident 49's room bathroom was cleaned including but not limited to around the toilet and the cove case throughout the room and the bathroom. Resident 49's door trim was repaired. Resident 49's floor was cleaned throughout the room. Resident 31's room floor was cleaned throughout the room. Resident 24's feeding tube pole and base and residents chair was cleaned. Residents 97 and 32's room floor was cleaned throughout the room. Residents 43, 71, and 50's room floors were cleaned throughout the entire room. 2. A facility wide audit will be completed to ensure all floors are cleaned including but not limited to		

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F 0584 SS=E	Continued from page 3	F 0584	<p>bathrooms, windowsills are cleaned, bathtub drains are cleaned, doors/doorframes are repaired if damaged, windows can close tightly, caulking around toilets are cleaned/repaired if damaged, privacy curtains are clean.</p> <p>3. Housekeeping Manager/designee was educated by NHA on appropriate cleaning of floors, walls, bathrooms, privacy curtains, and cove basing. Maintenance Director/designee was educated by NHA on doors/door frames being repaired if damaged, windows closing securely, capping end of water line pipes in bathrooms if needed.</p> <p>4. Housekeeping manager will audit 5 rooms weekly x 4 weeks to ensure rooms are cleaned properly. Maintenance Director will audit 4 door frames and 4 toilets with caulking weekly x 4 weeks to ensure repairs are completed if necessary. Results will be taken through QAPI.</p>		

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F 0584 SS=E	Continued from page 4 	F 0584			
F 0641 SS=D		F 0641			

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F 0641 SS=D	Continued from page 5 483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	1. Resident 5 and resident 82's MDS errors were corrected. 2. Facility audit will be done for any residents who are currently taking anticoagulants to ensure the MDS is accurate and facility audit will be done for any residents who are not taking anticoagulants to ensure the MDS is accurate. 3. RNAC/designee will be educated by Regional RNAC to ensure accuracy of MDS directly related to anticoagulants and drug classifications per the RAI Manual. 4. Regional RNAC/designee will audit 5 residents plus all new admissions weekly x 4 weeks to ensure MDS accuracy directly related to anticoagulants and drug classifications per the RAI Manual. Results will be taken through QAPI.	Completion Date: 05/02/2023 Status: APPROVED Date: 03/31/2023	

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F 0641 SS=D	Continued from page 6 Based on clinical record review and staff interview, it was determined that the facility failed to ensure complete and accurate Minimum Data Set (MDS) assessments for two of two residents reviewed (Residents 5 and 82). Findings include: Review of Resident 5's clinical record revealed a Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated February 23, 2023, indicating that the facility assessed him as taking an anticoagulant (blood thinner) seven days in the assessment period. There was no documented evidence in Resident 5's clinical record to indicate that he ever took an anticoagulant. Interview with the Nursing Home Administrator on March 17, 2023, at 9:07 AM confirmed that the MDS assessment dated February 23, 2023, that indicated Resident 5 received an anticoagulant medication was completed in error.	F 0641			

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F 0641 SS=D	Continued from page 7 Review of Resident 82's clinical record revealed an MDS dated December 8, 2022, that indicated the facility assessed her as not taking any anticoagulants. Review of Resident 82's physician orders revealed that she was ordered to take Eliquis (a blood thinner) 5 mg (milligrams) every day upon return from the hospital on December 1, 2022. Interview with the Administrator on March 16, 2023, at 10:36 AM confirmed the above findings for Resident 82. 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0641			
F 0656 SS=D		F 0656			

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F 0656 SS=D	Continued from page 8 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	1. Resident 20's careplan was updated to ensure resident receives medications that are ordered for the treatment of constipation if applicable. Resident 34's careplan was updated to provide information directly related to her specialized chair. 2. Facility audit will be done for any resident who has medications that are ordered for the treatment of constipation to ensure orders and careplans are appropriate. Facility audit will be done to ensure all specialty chairs have appropriate careplans, including new and readmissions. 3. Interdisciplinary team will be educated by NHA/designee on the importance of ensuring careplans specifically outline any specialty chair with a harnesses and an appropriate bowel and bladder careplan is completed if applicable. 4. DON/designee will audit 5 residents weekly 4 weeks who are on medications that are ordered for the treatment of constipation to ensure accuracy. DOR/designee will audit	Completion Date: 05/02/2023 Status: APPROVED Date: 03/31/2023	

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F 0656 SS=D	Continued from page 9 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656	all residents with specialty wheelchairs with harnesses to ensure the careplan is up to date accurately. Results will be taken through QAPI.		

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F 0656 SS=D	Continued from page 10 Based on clinical record review and resident and staff interview, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan to maintain the highest practicable well-being for two of 20 residents reviewed (Residents 20 and 34). Findings Include: Interview with Resident 20 on March 14, 2023, at 2:03 PM revealed that she has issues with constipation. She indicated that sometimes they give her something and sometimes they don't. Clinical record review for Resident 20 revealed current physician orders for the following medications to treat constipation: MiraLAX Powder 17 grams every 24 hours as needed for constipation, Senna Tablet 8.6 milligrams give one tablet every 24 hours as needed for constipation, and Enulose 10 grams per 15 milliliters (ml) give 45 ml every 24 hours as needed for constipation and Colace capsules one capsule every 12 hours as	F 0656			

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F 0656 SS=D	<p>Continued from page 11</p> <p>needed for constipation.</p> <p>Review of Resident 20's Bowel movement documentation revealed that she had no bowel movement from January 30, 2023, through February 4, 2023. Review of her medication administration record (MAR) revealed that she did not receive any of the as needed medications listed above after going 6 days without a bowel movement, until February 5, 2023 (day 7 with not bowel movement).</p> <p>Further review of Resident 20's bowel movement documentation revealed that she did not have a bowel movement from February 6 to 8, 2023, (3 days) February 10 to 12, 2023, (3 days), February 14 to 18, 2023 (5 days), and February 25 to 28, 2023 (4 days), and was not provided with any of her medications that were ordered for the treatment of constipation.</p> <p>Interview with the Director of Nursing on March 16, 2023, at 10:42 AM confirmed the above</p>	F 0656			

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F 0656 SS=D	Continued from page 12 noted findings that the facility failed to develop and implement a person-centered care plan for Resident 20 related to constipation. Observation on March 14, 2023, at 11:14 AM revealed Resident 34 was sitting in the hallway in a specialized tilt chair with a shoulder harness across the chest and seatbelt across the waist. Review of Resident 34's diagnostic list revealed the resident had Spastic Quadriplegia (disabling increased muscle tone causing movements to be stiff and awkward. displaying jerkiness of arms, legs, and trunk and sometimes the face, which places the person at risk for contractures or loss of joint motion that can be painful, making joint movement difficult for dressing/bathing/other activities, and places the person at risk for pressure ulcers between the joints). Review of Resident 34's physician's orders revealed that staff were to provide a standard wheelchair with a seatbelt, shoulder harness, and anti-tip attachment	F 0656			

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F 0656 SS=D	Continued from page 13 effective July 22, 2022. There was no documented evidence that the care plan for Resident 34 included specific interventions on the resident's wheelchair seating as outlined above. During an interview with the Nursing Home Administrator and Employee 6, Director of Therapy, on March 16, 2023, at 11:40 AM confirmed that Resident 34's care plan lacked the specialized safe seating requirements. 28 Pa. Code 211.11 (d) Resident care plan	F 0656			
F 0684 SS=D		F 0684			

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F 0684 SS=D	Continued from page 14 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	1. Resident 20's MAR was updated to ensure resident receives medications that are ordered for the treatment of constipation if applicable. 2. Facility audit will be done for any resident who has medications that are ordered for the treatment of constipation to ensure orders are appropriate. 3. Licensed staff will be educated by DON/designee to ensure medications are administered appropriately related to constipation. The bowel list will be reviewed during clinical rounds to ensure appropriate follow-up is completed. 4. DON/designee will audit 5 residents weekly 4 weeks who are on medications that are ordered for the treatment of constipation to ensure accuracy. Results will be taken through QAPI.	Completion Date: 05/02/2023 Status: APPROVED Date: 03/31/2023	

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F 0684 SS=D	<p>Continued from page 15</p> <p>Based on select policy review, clinical record review, and staff and resident interview, it was determined that the facility failed to provide the highest practicable care regarding bowel management for one of one resident reviewed (Resident 20).</p> <p>Findings include:</p> <p>The policy and procedure entitled "Bowel Protocol" last reviewed without changes on January 25, 2023, revealed the purpose was to identify residents at risk for constipation to implement a bowel regime to maintain comfort and avoid complications.</p> <p>Interview with Resident 20 on March 14, 2023, at 2:03 PM revealed that she has problems with constipation. She indicated that sometimes they give her something and other times they don't.</p> <p>Review of Resident 20's current physician orders revealed that she had multiple medications ordered PRN (as needed) for the treatment of constipation</p>	F 0684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395396	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 03/17/2023
NAME OF PROVIDER OR SUPPLIER: WILLIAMSPORT SOUTH REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: 641502		STREET ADDRESS, CITY, STATE, ZIP CODE: 101 LEADER DRIVE WILLIAMSPORT, PA 17701			
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F 0684 SS=D	Continued from page 16 with the same parameters: MiraLAX Powder (used to treat constipation) 17 grams every 24 hours as needed for constipation Senna Tablet (used to treat constipation) 8.6 milligrams give one tablet every 24 hours as needed for constipation Enulose (used to treat constipation) 10 grams per 15 milliliters (ml) give 45 ml every 24 hours as needed for constipation. She also had an order for Colace capsules (a stool softener) one capsule every 12 hours as needed for constipation and MiraLAX Powder 17 grams to be given on day 3 or day 4 with no bowel movement. Review of Resident 20's Bowel movement documentation revealed that she had no bowel movement from January 30, 2023, through February 4, 2023. Review of her medication administration record (MAR) revealed that she did not receive any of the as needed medications listed above after going 6 days without a bowel movement, until February 5, 2023 (day 7 with not	F 0684			

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F 0684 SS=D	Continued from page 17 bowel movement). Further review of Resident 20's bowel movement documentation revealed that she did not have a bowel movement from February 6-8, 2023, (3 days) February 10-12, 2023, (3 days), February 14-18, 2023 (5 days), and February 25-28, 2023 (4 days), and was not provided with any of her medications that were ordered for the treatment of constipation. Interview with the Director of Nursing on March 16, 2023, 2023, at 10:42 AM confirmed the above noted findings that the facility failed to provide the highest practicable care regarding bowel management for Resident 20. 28 Pa. Code: 211.10(a)(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0684			

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F 0688 SS=E	<p>483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility</p> <p>§483.25(c) Mobility.</p> <p>§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and</p> <p>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 0688	<p>1. Resident 34's restorative program was re-initiated that was recommended by physical therapy and occupational therapy for both upper and lower extremities.</p> <p>2. Facility audit will be completed to review all restorative programs that have been recommended by the therapy department in the last 30 days to ensure all programs are active.</p> <p>3. Interdisciplinary team will be educated by NHA/designee regarding importance of ensuring restorative programs are active as they are recommended from the therapy department. New recommendations will be reviewed during clinical rounds.</p> <p>4. UM/designee will audit 5 residents weekly x 4 weeks to ensure all restorative programs are active and appropriate. Results will be taken through QAPI.</p>	<p>Completion Date: 05/02/2023 Status: APPROVED Date: 03/31/2023</p>	

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F 0688 SS=E	<p>Continued from page 19</p> <p>Based on observation, clinical record review, and staff interview, it was determined that the facility failed to implement treatment to prevent a decline in range of motion for one of four residents reviewed (Resident 34).</p> <p>Findings include:</p> <p>Observation on March 14, 2023, at 11:14 AM revealed Resident 34 was sitting in the hallway in a specialized tilt chair with a shoulder harness across the chest and seatbelt across the waist. Resident 34 was non-communicative and had no purposeful movement.</p> <p>Review of Resident 34's diagnostic list revealed the resident had Spastic Quadriplegia (disabling increased muscle tone causing movements to be stiff and awkward. displaying jerkiness of arms, legs, and trunk and sometimes the face, which places the person at risk for contractures or loss of joint motion that can be painful, making joint movement difficult for dressing/bathing/other activities, and</p>	F 0688			

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F 0688 SS=E	Continued from page 20 places the person at risk for pressure ulcers between the joints). Review of a Physical Discharge Summary dated July 19, 2022, for Resident 34 revealed the resident was referred for an RNP (Restorative Nursing Program, a program performed to help residents improve or maintain overall functioning) for ROM (range of motion exercises) to the lower extremities (legs to feet) twice daily. Review of an Occupation Discharge Summary dated August 1, 2022, for Resident 34 revealed the resident was referred for an RNP for ROM to the bilateral upper extremities (arm to the hand) twice daily. Clinical record review for Resident 34 revealed no documentation of any RNP for Resident 34. During an interview with the Nursing Home Administrator and Employee 6, Director of Therapy, on March 16, 2023, at 11:40 AM it was	F 0688			

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F 0688 SS=E	Continued from page 21 confirmed that the ROM programs were inadvertently stopped on November 17, 2022, and the programs will be restarted. 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0688			
F 0692 SS=E		F 0692			

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F 0692 SS=E	Continued from page 22 483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 0692	1. Residents 1, 5, 82, 41, and 52, comprehensive nutrition assessments were completed by the Registered Dietitian (RD). Nutrition and Dietetics Technician, Registered (NDTR) interviewed residents/caregivers to review food preferences; Dietary Director updated the dietary database. Physicians were updated on weight trends and interventions. 2. Current residents with weight loss will be audited to ensure appropriate interventions and notifications are in place. 3. The NDTR and RD have been re-educated by Corporate RD regarding weight loss monitoring, interventions, and notification best practices. 4. Corporate RD/designee will conduct random weekly audits x 4 and monthly for 2 months to ensure weight loss monitoring, interventions and notifications are being followed as per policy. Results will be submitted to QAPI.	Completion Date: 05/02/2023 Status: APPROVED Date: 03/31/2023

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F 0692 SS=E	Continued from page 23 Based on clinical record review, review of select facility policies and procedures, and staff interview, it was determined that the facility failed to provide timely assessment and implement interventions to promote acceptable parameters of nutritional status for 5 of 6 residents reviewed for nutritional concerns (Residents 1, 5, 41, 52, and 82). Findings include: The facility policy entitled "Weight Protocol," last reviewed without changes on January 25, 2023, revealed it is the facility policy to weigh each resident on admission, then weekly for four weeks, then monthly thereafter, unless otherwise ordered by physician. Each resident will be weighed by the 10th day of the month. Any resident with weight changes of five or more pounds will be re-weighed no later than 24 hours post the original weight by the assigned nurse aide and nurse. Any resident displaying a change of greater than or equal to five pounds gain or loss in one month will be reported to the dietician for review. The dietician will review the	F 0692			

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F 0692 SS=E	Continued from page 24 medical record of residents with significant weight changes of five percent in one month, seven and a half percent in three months, or 10 percent in six months, and interventions will be recommended as needed. The nurse will confirm with the physician any order recommendations made by the dietician. Interventions that are initiated in response to a weight change will be reflected in the residents' care plan. Residents with significant weight loss or gain will be further reviewed in the interdisciplinary team meetings. Interview with Resident 1 on March 14, 2023, at 11:16 AM revealed that she does not like the food and stated she is not eating much and losing weight. Resident 1 stated that she requested toast in place of her normal food tray and Resident 1 stated that she does not receive it. Clinical record review for Resident 1 revealed weight documentation in Matrix Care (electronic medical record) indicating the following weights for Resident 1:	F 0692			

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F 0692 SS=E	<p>Continued from page 25</p> <p>December 3, 2022, 198 pounds February 21, 2023, 174.6 pounds (23.4 pounds, 11.82 percent severe weight loss in 3 months)</p> <p>Further review of Resident 1's clinical record revealed there was no assessment of Resident 1's February 21, 2023, severe weight loss. The last nutritional assessment was on February 20, 2023, prior to staff obtaining Resident 1's weight identifying the severe weight loss.</p> <p>Clinical record review for Resident 5 revealed weight documentation in Point Click Care (electronic medical record) indicating the following weights for Resident 5:</p> <p>September 2, 2022, 130.0 pounds October 31, 2022, 120.5 pounds (9.5 pounds, 7.31 percent significant weight loss)</p> <p>Further review of Resident 5's clinical record revealed there was no assessment of Resident 5's October 31, 2022, significant weight loss. The last</p>	F 0692			

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F 0692 SS=E	Continued from page 26 nutritional assessment was on November 28, 2022, and there was no documentation addressing Resident 5's significant weight loss. Interview with Employee 2 (dietary technician) on March 16, 2023, at 10:25 AM confirmed the above findings for Residents 1 and 5. Employee 2 indicated the registered dietician was not made aware of their severe and significant weight loss, respectively. Review of Resident 82's clinical record revealed that the facility weighed her on November 1, 2022, at 197 pounds. Resident 82 was weighed on February 1, 2023, at 175 pounds, an 11 percent severe weight loss in three months. Review of Resident 82's nutritional notes revealed a nutritional progress note a month after the severe weight loss was noted, completed by a diet technician on March 9, 2023, indicating that Resident 82 experienced a significant weight loss and that the weight loss is desired. There was no	F 0692			

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F 0692 SS=E	Continued from page 27 documented evidence in Resident 82's clinical record to indicate that the Registered Dietician or her physician was notified of the weight loss. Interview with Employee 2 on March 16, 2023, at 10:35 AM confirmed the above information for Resident 82 Clinical record review for Resident 41 revealed a nutrition/weight note dated January 3, 2023, at 3:10 PM by a diet technician, revealed that she had a significant weight loss of 7.5 percent in 3 months. Her current body weight on January 1, 2023, was 137.5 pounds. Her body weight on October 3, 2022, was 149.5 pounds. The note indicated that Resident 41 would receive whole milk three times a day, yogurt, banana, and peanut butter in addition to breakfast and ice cream with lunch and dinner and snacks in the morning and afternoon. A nutrition/weight note dated January 19, 2023, at 5:23 PM by a diet technician revealed that Resident 41's current weight was 138.5 pounds. A significant	F 0692			

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F 0692 SS=E	<p>Continued from page 28</p> <p>3-month weight loss noted from her October 25, 2022, weight of 150.7 pounds to her current weight of 138.5 pounds. Nutritional juice at breakfast and between meals was initiated. An ongoing nutrition monitoring was to continue.</p> <p>A nutrition/weight note dated January 31, 2023, at 4:33 PM by a diet technician revealed that Resident 41 had a significant weight loss in one month and in 3 months. Her current weight was 135 on January 31, 2023, and the previous weights were 143.5 on December 27, 2022, and 150.7 on October 25, 2022. No new interventions were initiated at this time.</p> <p>There were no further assessments or progress notes from the diet technician or dietician until March 9, 2023, at which time Resident 41 continued to have weight loss.</p> <p>There was no evidence in the clinical record that the dietician was notified of Resident 41's significant weight loss on January 3, 2023, January 19, 2023,</p>	F 0692			

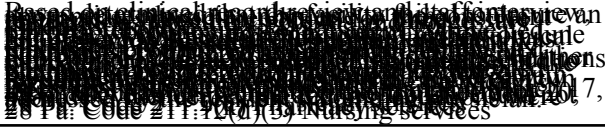
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F 0692 SS=E	Continued from page 29 or January 31, 2023. There was no evidence that Resident 41's physician was made aware of her significant weight loss on January 31, 2023. The above noted finding related to Resident 41's weight loss were reviewed with the Nursing Home Administrator on March 17, 2023, at 9:12 AM. Clinical record review for Resident 52 revealed the following weights: September 2, 2022, 104 pounds October 4, 2022, 107 pounds November 8, 2022, 108 pounds December 30, 2022, 89.5 pounds (17.13 percent severe weight loss or 18.5-pound loss since the last monthly weight and 14.42 percent loss or 14.5-pound loss in 6 months) January 4, 2023, 88 pounds February 2, 2023, 87 pounds February 6, 2023, 89 pounds March 5, 2023, 89 pounds	F 0692			

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F 0692 SS=E	<p>Continued from page 30</p> <p>Review of a progress note for Resident 52 by Employee 2 dated January 4, 2023, at 4:07 PM revealed the resident had a significant weight loss of 19 pounds or 17.6 percent loss in one month and the weight was stable for three and six months. The resident's meal completion was 76 to 100 percent. Nutritional juice at breakfast and lunch, and an afternoon and bedtime snack were implemented. There was no documentation that the physician, registered dietitian, or family was notified of the weight loss and there was no indication that more than monthly weights were ordered.</p> <p>Clinical record review for Resident 52 revealed no documented nutritional note or assessment was completed for February 2023.</p> <p>Clinical record review for Resident 52 revealed a note by Employee 2 dated March 15, 2023, at 7:42 AM that indicated the resident had a significant weight gain of one pound and weight has stabilized. The resident's BMI (Body Mass Index, according to the CDC, Center for Disease Control and</p>	F 0692			

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NAME OF PROVIDER OR SUPPLIER: WILLIAMSPORT SOUTH REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: 641502			STREET ADDRESS, CITY, STATE, ZIP CODE: 101 LEADER DRIVE WILLIAMSPORT, PA 17701		
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F 0692 SS=E	<p>Continued from page 31</p> <p>Prevention, a BMI of 18.5 is considered underweight) was 17.4</p> <p>During an interview with the Nursing Home Administrator on March 16, 2023, at 3:00 PM the surveyor questioned why Resident 52 did not have a weight at the start of December 2022, instead of December 30, 2022, and why the resident's weight gain was significant when there was only a one-pound gain, and why the registered dietitian and physician were not notified of the resident's severe weight loss.</p> <p>On March 17, 2023, clinical record review for Resident 52 revealed that the above note dated March 15, 2023, was crossed out and a progress note by Employee 2 dated March 16, 2023, at 4:36 PM was entered. The note revealed the resident had a significant weight loss noted per electronic medical record. The resident's current weight was 89 pounds and had a BMI of 17.4. The weight loss stabilized, and the resident had a one-pound beneficial gain the past month.</p>	F 0692			

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F 0692 SS=E	Continued from page 32 During an interview with the Nursing Home Administrator on March 17, 2023, at 9:23 AM it was confirmed that the registered dietitian and physician were not notified of Resident 52's severe weight loss, and the resident's monthly weight was not performed timely. Cross Refer to F801 28 Pa. Code 211.6 (d) Dietary services 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services	F 0692			
F 0756 SS=D		F 0756			

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F 0756 SS=D	Continued from page 33 483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 0756	1. Physician will submit a response pharmacy recommendations for residents 20, 41, and 60. 2. Facility audit will be completed of all pharmacy recommendations for the last 30 days to ensure physicians have responded to each of them. 3. Interdisciplinary team will be educated by NHA/designee regarding requiring each pharmacy recommendation to have physician follow up. 4. DON/designee will audit 5 pharmacy recommendations weekly x 4 weeks to ensure physician are responding to recommendations. Results will be taken through QAPI.	Completion Date: 05/02/2023 Status: APPROVED Date: 03/31/2023	

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F 0756 SS=D	Continued from page 34 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:  Based on clinical audit of facility and staff interview conducted on 03/17/2023, the facility failed to meet the requirement of §483.45(c)(5) Nursing Services.	F 0756			
F 0801 SS=E		F 0801			

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F 0801 SS=E	Continued from page 35 483.60(a)(1)(2) Qualified Dietary Staff §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered	F 0801	1. Director of Dietary will enroll with the National Serve Safe Manager Certification by 4/1/2023 to become Certified. Dietary Director is currently working as his 11th year as Food Service Director as well as completing a 2 year interim as the Food Service Director. 2. Dietary Director will be educated by Regional Dietary Director about the necessary requirements for the Food Service Director. 3. Audit Certification quarterly x 2 quarters to ensure that the Director of Dietary has completed and is within compliance with the National Serve Safe Certification. Results will be taken through QAPI.	Completion Date: 05/02/2023 Status: APPROVED Date: 03/31/2023	

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F 0801 SS=E	Continued from page 36 dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or (D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State	F 0801			

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F 0801 SS=E	Continued from page 37 requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by:	F 0801			

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F 0801 SS=E	Continued from page 38 Based on staff interview and a review of employee credentials, it was determined that the facility failed to employ sufficient staff with appropriate competencies to carry out functions of the food and nutrition service (Employees 2 and 5). Findings include: Interview with the Nursing Home Administrator on March 16, 2023, at 9:05 AM revealed that the facility does not employ a registered dietician. She stated Employee 2 consults with a registered dietician from another facility one day a week. Review of Employee 2's personnel file and interview with the Nursing Home Administrator on March 17, 2023, at 10:30 AM revealed Employee 2 was hired as a full-time dietary technician on August 23, 2022. Review of Employee 5's personnel file revealed the facility hired him on October 18, 2022, as director of food and nutrition. There was no evidence Employee 5 had the qualifications of food service manager certification/degree, or a certified dietary	F 0801			

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F 0801 SS=E	Continued from page 39 manager credential in the absence of a full-time qualified dietitian. During an interview on March 17, 2023, at 11:10 AM the Nursing Home Administrator acknowledged the facility did not employ an individual on a full-time basis who possessed the regulatory required qualifications to provide oversight of the dietary department in the absence of a full time Registered Dietitian. Cross Refer to F692 28 Pa. Code 211.6(c)(d) Dietary services 28 Pa Code 201.18(e)(1)(6) Management	F 0801			
F 0888 SS=D		F 0888			

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F 0888 SS=D	Continued from page 40 483.80(i)(1)-(3)(i)-(x) COVID-19 Vaccination of Facility Staff §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified	F 0888	Employee 4 is partially vaccinated and will be fully vaccinated as soon as she is eligible for the second dose. 2. Facility audit will be completed of all current staff to ensure staff begin their covid-19 vaccine series prior to first day of work or have a completed medical or religious exemption form completed prior to the first day of working. 3. All department head managers will be educated by NHA/designee to ensure staff begin their covid-19 vaccine series prior to first day of work or have a completed medical or religious exemption form completed prior to the first day of working. 4. HRD/designee will audit each new hire employee weekly x 4 weeks to ensure staff begin their covid-19 vaccine series prior to first day of work or have a completed medical or religious exemption form completed prior to the first day of working. Results will be taken through QAPI.	Completion Date: 05/02/2023 Status: APPROVED Date: 03/31/2023	

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F 0888 SS=D	Continued from page 41 in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i) (1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption	F 0888			

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F 0888 SS=D	Continued from page 42 from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent	F 0888			

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F 0888 SS=D	Continued from page 43 plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by:	F 0888			

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F 0888 SS=D	Continued from page 44 Based on review of the Centers for Medicare and Medicaid (CMS) directives, employee vaccination information, and staff interview, it was determined that the facility failed to ensure that all staff were fully vaccinated for COVID-19, except for those granted exemption status as recommended by the Centers for Disease Control (CDC) and CMS guidelines (Employee 4). Findings include: A review of a Department of Health & Human Services, Center for Clinical Standards and Quality/ Quality, Safety & Oversight Group dated October 26, 2022, QSO 23-02-ALL memo stated that there is a process for ensuring all staff (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19	F 0888			

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F 0888 SS=D	Continued from page 45 vaccine, or the first dose of the primary vaccination series for a multi dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents. Review of Employee 4's, housekeeping, COVID-19 vaccination status information revealed that the employee did not receive a first dose of a multiple dose vaccine series prior to starting employment. Review of facility documentation revealed that Employee 4 began employment on February 21, 2023. Employee 4 did not receive the first dose of a multiple dose of a COVID-19 vaccine until March 1, 2023. During an interview with the Nursing Home Administrator and Employee 3, Human Resource Director, on March 15, 2023, at 1:15 PM confirmed that Employee 4 declined to file for an approved exemption on the date of hire and the employee did not meet the criteria for a temporary delay. The facility scheduled her for the first dose of a multiple dose vaccine for the next vaccine clinic day.	F 0888			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395396	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 03/17/2023
NAME OF PROVIDER OR SUPPLIER: WILLIAMSPORT SOUTH REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: 641502			STREET ADDRESS, CITY, STATE, ZIP CODE: 101 LEADER DRIVE WILLIAMSPORT, PA 17701		
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F 0888 SS=D	<p>Continued from page 46</p> <p>The Nursing Home Administrator provided a signed statement written from Employee 4 on March 16, 2023, at 10:21 AM, which was written the same date and indicated that the employee received the exemption forms for the COVID-19 vaccine at new hire orientation. The employee indicated that she changed her mind and decided on receiving the vaccines and as soon as she told the employer, the employee was able to get vaccinated.</p> <p>Immediately after reading the above statement, the surveyor re-interviewed Employee 3 and confirmed that Employee 4 told her on the day of hire that she did not want to file an exemption and wanted the COVID-19 vaccine, and the facility failed to provide Employee 4 with the first dose of a multiple dose COVID-19 vaccine prior to providing services for the facility and/or its residents.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee</p> <p>28 Pa. Code 201.18(b)(1)(d)(e)(1) Management</p>	F 0888			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395396		(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 03/17/2023	
NAME OF PROVIDER OR SUPPLIER: WILLIAMSPORT SOUTH REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: 641502				STREET ADDRESS, CITY, STATE, ZIP CODE: 101 LEADER DRIVE WILLIAMSPORT, PA 17701			
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F 0888 SS=D	Continued from page 47			F 0888			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395396	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 03/17/2023
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P 1895	<p>§ 211.9(j) Pharmacy services.</p> <p>(j) Disposition of discontinued and unused medications and medications of discharged or deceased residents shall be handled by facility policy which shall be developed in cooperation with the consultant pharmacist. The method of disposition and quantity of the drugs shall be documented on the respective resident's chart. The disposition procedures shall be done at least quarterly under Commonwealth and Federal statutes.</p> <p>This REGULATION is not met as evidenced by:</p>	P 1895	<p>1. Residents 101 and 102 were discharged from the facility. Therefore, corrective action of the disposition of medications are not able to be done.</p> <p>2. A facility audit will be completed for the last 30 days of all discharged or expired residents to ensure the disposition of medications has been done appropriately.</p> <p>3. Licensed staff will be educated by DON/designee on ensuring all discharged or expired residents to ensure the disposition of medications will be done appropriately.</p> <p>4. DON/designee will audit all discharges and deaths weekly x 4 weeks to ensure the disposition of medications are being done appropriately. Results will be taken through QAPI.</p>	<p>Completion Date: 05/02/2023 Status: APPROVED Date: 03/31/2023</p>	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE:		(X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395396	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 03/17/2023
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P 1895	<p>Continued from page 1</p> <p>Based on closed clinical record review and staff interview, it was determined that the facility failed to account for the disposition of medications upon discharge for two of three residents reviewed (Residents 101 and 102).</p> <p>Findings include:</p> <p>Closed clinical record review for Resident 101 revealed that the resident was admitted to the facility on September 2, 2022, and expired on January 2, 2023.</p> <p>The Medication Administration Record (MAR, a form used to document the administration of medications) for Resident 101 revealed the resident was prescribed the following medications:</p> <p>Lisinopril (treats high blood pressure) 10 mg (milligrams) every day Oxybutynin Chloride (treats overactive bladder) 5 mg every day Tamiflu (treats influenza symptoms) 75 mg every</p>	P 1895			

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395396	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 03/17/2023
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P 1895	<p>Continued from page 2</p> <p>day</p> <p>Trazadone (treats depression) 50 mg at bedtime</p> <p>Metoprolol Tartrate (treats high blood pressure) 25 mg twice a day</p> <p>Gabapentin (used to treat seizures or control nerve pain) 600 mg three times a day</p> <p>There was no documented evidence in Resident 101's closed clinical record to indicate that the facility accounted for the disposition or the amount of the above medications upon her discharge. Interview with the Director of Nursing on March 17, 2023, at 12:55 PM, confirmed that a printout of returned medications was obtained from the pharmacy after the surveyor brought up the concern.</p> <p>Closed clinical record review for Resident 102 revealed that the resident was admitted to the facility on November 14, 2022. Resident 102 left against medical advice on January 31, 2023.</p> <p>A physician's order was written on January 31, 2023, for the facility to discharge Resident 102</p>	P 1895			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395396	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 03/17/2023
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P 1895	<p>Continued from page 3</p> <p>home with medications.</p> <p>The MAR for Resident 102 revealed the resident was prescribed the following medications:</p> <p>Hydrochlorothiazide (a fluid pill used to treat high blood pressure and fluid buildup) 25 mg one time a day</p> <p>Quetiapine Fumarate (a medication used to treat bipolar or schizophrenia disorders) 25 mg one tablet daily at bedtime.</p> <p>There was no documented evidence in Resident 102's closed clinical record to indicate that the facility accounted for the disposition or the amount of the above medications upon her discharge.</p> <p>Interview with the Nursing Home Administrator on March 17, 2023, at 10:41 AM confirmed that there was no documented evidence in Resident 102's closed clinical record to indicate the disposition of the above medications on her discharge to home.</p>	P 1895			



Certified End Page

WILLIAMSPORT SOUTH REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 641502

SURVEY EXIT DATE: 03/17/2023

**I Certify This Document to be a True and Correct Statement of Deficiencies and
Approved Facility Plan of Correction for the Above-Identified Facility Survey**

A handwritten signature in black ink that reads "Jeane Parisi".

Jeane Parisi
Deputy Secretary for Quality Assurance

A handwritten signature in black ink that reads "Debra L. Bogen MD".

Debra L. Bogen, MD, FAAP
Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY